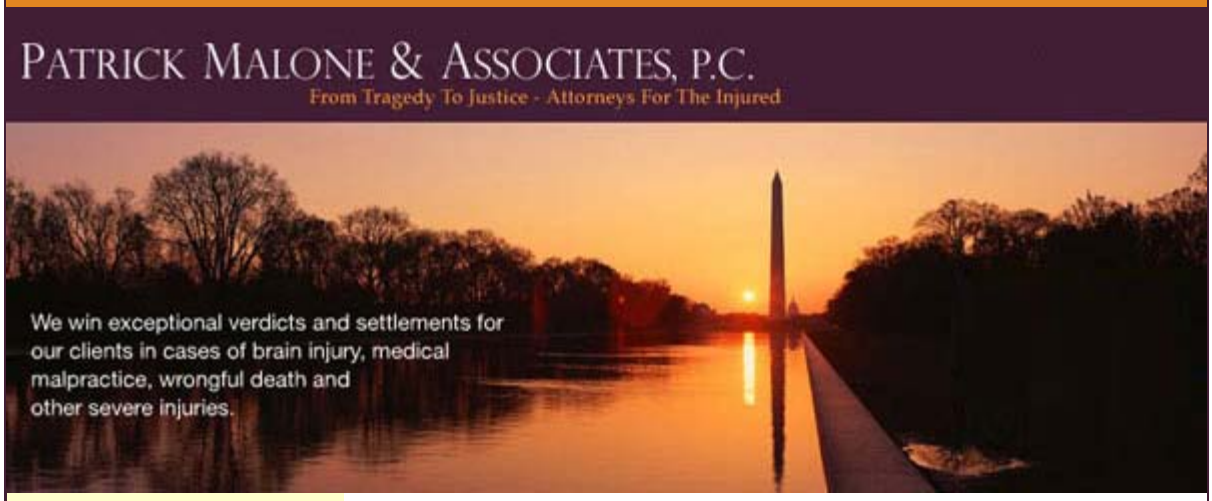
Getting the Best Medical Care: a Newsletter from Patrick Malone



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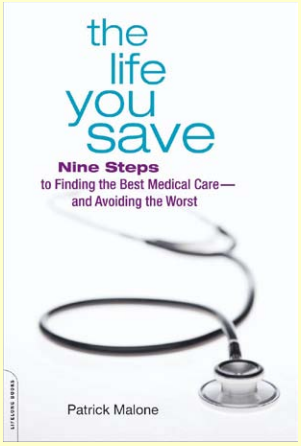
Our firm's website

Read an excerpt from Patrick Malone's book:

The Life You Save: Nine Steps to Finding the Best Medical Care -- and Avoiding the Worst



When Your Health Insurer Denies a Claim, Do You Have to Roll Over?

Thanks to the Affordable Care Act ("Obamacare"), no one seeking health insurance coverage can be denied because of a pre-existing condition. But that doesn't mean an insurance company must cover every medical service you want or need. And sometimes, it denies coverage you're entitled to have.

When you sign up for an insurance plan, you're given a book with an often-daunting explanation of coverage that is supposed to help you understand what's covered and what isn't. Still, it's often a disappointing and expensive surprise when medical services you expected to be covered are denied by the insurer.

Coverage can be denied when you and your doctor first request it, or after the treatment, and you find yourself stuck with a big bill.

This month, we look at health insurance denials and what you can do to reverse them.

How One Consumer Challenged a Denial

Rules for filing an appeal used to vary by state and employer (and still might, for older insurance plans), but the ACA established national standards for appeals to insurance companies and, if necessary, to a third-party reviewer. It is your right to challenge denied coverage, but it can be time-consuming and it requires you to be organized and to have supporting material.

A federal government report from 2011 that reviewed data from a handful of states before the ACA took effect found that patients were successful in as many as 6 in 10 cases if they appealed directly to the insurer. If they appealed to a third party, such as a state insurance commissioner, the results were equally positive. In Maryland, for example, about 54 in 100 patients won third-party

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appeals.

Tony Simek, a software engineer in Arizona, suffered from sleep apnea so extreme that he would fall asleep while driving. The disorder, which is diagnosed after a patient undergoes a monitored sleep test, can be treated with a range of interventions. One of them is a machine called a CPAP (continuous positive airway pressure) used overnight that forces air into the respiratory system.

Simek had a CPAP, but when his symptoms worsened, his doctor, in a story told by KaiserHealthNews (KHN) and NPR, advised him to undergo another sleep lab study to see if it required adjustment. His insurance company declined to pay for the test, claiming it was "not medically necessary" to treat his condition.

Without coverage, the cost for such tests, depending on the lab, the region and how extensive they are, can range from $500 to several thousand dollars.

After trying, without success, to get approval during several phone calls, Simek filed an appeal with the California Department of Insurance, where his job-based health plan is provided through a California employer. In California, one analysis showed that patients who appeal denials win about half the time.

More below on what happened to Simek's appeal, but meantime, here's what you need to do.

Why Were You Denied?

Before you file an appeal, make sure you understand why your request or claim was denied. Get a clear account from the insurance company so that when you do appeal, you directly address the reason it gives for the denial.

If you are denied payment for a treatment or service, and your plan was in effect on or after July 1, 2011, the insurer is required to notify you:

- why your claim was denied;
- that you have the right to file an internal appeal ("internal" is with the insurance company);
- that you have the right to request an external review if your internal appeal is unsuccessful ("external" is with a third party, such as a state insurance department);
- of the availability of a Consumer Assistance Program, if your state has one (see information below).

In addition, your plan book includes an explanation of how to appeal a denial, and the contact information.

The ACA's provisions on internal appeals and external reviews apply only to health plans or policies that were created or purchased after March 23, 2010. Older plans are "grandfathered," or excused from ACA requirements. The appeals and review rights do not apply to them, but they are gradually disappearing from the scene.

Preparing for a Successful Appeal

According to the Patient Advocate Foundation, a successful appeal is more likely if you:

1. Gather preliminary information.
2. Understand the illness and the insurance.
3. Write the appeal letters.
4. Figure out why the denial happened.

Each step is spelled out in the foundation's guide to the appeals process.

Sometimes, a denial is just a misunderstanding -- the insurer might not have understood why the service was needed and how it fit within its coverage. In many of these cases, it's easier (and less expensive) for the company just to say "no" than inquire further.

One KHN report recalled the case of a woman whose insurer sent her newborn son a $600 bill because he'd neglected to inform the company that he'd be in the hospital for a few days. "Apparently he was supposed to call before being born," she commented.

She appealed and, of course, won.

Sometimes it's a paperwork issue. If the Current Procedural Terminology (CPT) code that describes the procedure you received doesn't correspond to the ICD (International Statistical Classifications of Diseases) code that describes your diagnosis, your claim could be denied, and probably described as a "reason code" on your explanation of benefits (EOB).

The CPT code must conform to the age, gender and place of service, so if the code is for an adult's test, but the patient is a child, the result could be a denial.

Your doctor's office might have erred on the code, or the doctor might not have made the most complete case for your request. The Patient Advocate Foundation guide helps you make sure that he or she has fully described the need for your treatment, and used the correct codes.

Administrative errors can prompt a denial of coverage. The insurance company might have entered data incorrectly -- your name, plan or ID number, or the CPT code. In your initial discussion for an appeal, verify that they have the correct information to identify you, your plan and your requested procedure.

If your claim is denied because the treatment isn't considered "medically necessary," or is deemed "experimental or investigational," that's indicated on your EOB. Ask your doctor or insurer to cross-check the treatment with the diagnosis to ensure they're in sync.

If your denial stems from the insurer's judgment that the surgery, drug or whatever service your doctor has deemed necessary is "experimental," you can demonstrate its legitimacy with medical studies (your doctor can supply this information) and FDA approvals. All medical devices and drugs must be approved by the FDA before they can be marketed. Learn more about FDA-approved products here.

"The more evidence that's available about the appropriateness and

effectiveness of a particular drug or treatment or technology -- that's what drives what's covered," Robert Zirkelbach, who represents an insurance industry trade group, told KHN/NPR.

If you're requesting something that truly is experimental, you are not likely to get it through your insurer -- we've never heard of an insurance plan that covers tests or treatments undergoing trials, and this is made clear in the book describing your plan. (On the other hand, when you enroll in a clinical trial program, you often get the treatment free as an incentive to participate.)

Getting Help With an Appeal

Health plans created after March 23, 2010, are subject to the appeals process defined by the ACA, regardless of whether they're employer or individual plans. If the internal appeal results in a denial, you're entitled to an independent review by an outside organization -- the external review.

If the external reviewer overturns your insurer's denial, your insurer must pay up.

Many states have a health-care consumer assistance programs to assist with filing your appeal or requesting a review. To find the one in your state, consult the website of The Center for Consumer Information & Insurance Oversight. For the District of Columbia, link here; for Maryland, link here.

If your state isn't listed among those with such a program, the website offers other consumer resources: phone numbers, email addresses and links to your each state's Department of Insurance that might be helpful.

The Patient Advocate Foundation also offers assistance. If you are covered by an employer-sponsored health plan, the U.S. Department of Labor's Employee Benefits Security Administration can assist. Link here, or call (866) 444-3272.

When you request an internal appeal -- that is, the appeal directly to your insurance company -- your plan must give you its decision within:

- 72 hours after receiving your request if you're appealing the denial of a claim for urgent care. (If so, you might be able to have the internal appeal and external review simultaneously.);
- 30 days for denials of nonurgent care you have not received;
- 60 days for denials of services you have received.

For appeals to a Medicare denial of coverage, link here. You also can call Medicare's claims and appeals department at (800 633-4227.

Another government assistance agency is the State Health Insurance Assistance Program (SHIP),where you can search by state for one-on-one counseling and assistance for people covered by Medicare.

One private resource is the Medicare Rights Center, a consumer advocacy group. It advises about appeals, and other Medicare information at (800) 333-4114.

Don't be timid in seeking an appeal for a denial of coverage: It's your right, and if you're like Tony Simek, you'll be glad you made the effort. A California regulator overruled his insurer, he got the test and reports that "I have been sleeping well ever since."

Big Payoff for a Persistent Consumer

Just as we were going to press with this issue, we read the story of an Albuquerque MS patient named Dave Bexfield. Dave just got wired a payment of $402,000 from his health insurer to pay him back for a stem cell transplant treatment that he'd been haggling over with the insurer for four long years. Half the money was interest. Bexfield endured many, many denials of coverage, even though he discovered the insurer had approved the stem cell treatment for coverage only a few months after he finished his treatment. He filed Freedom of Information Act requests (his insurance plan was for federal employees) and just kept dogging the insurer until it finally ran up the white flag. Read more about his story in the New York Times' well-named financial column, "The Haggler."

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you.

- Two doctor leaders of the patient safety movement, Peter Pronovost of Johns Hopkins and Ashish Jha of Harvard, testified at a recent U.S. Senate hearing on how to improve hospitals' woeful record in protecting patients from harm. Consumer advocate Lisa McGiffert also spoke about how hospitals need to list the veil of silence that shrouds mistakes when they occur.
- Many men diagnosed with prostate cancer submit to "chemical castration," a drug that blocks their testosterone. New evidence questions why this should be routine practice.
- When your nearby hospital offers "free" screening for various medical conditions, it's a good idea to remember that nothing is ever really free. Some hospitals are in the fear-mongering business so they can get customers. That blunt and unfortunate reality was spelled out in a recent Public Citizen campaign to get some hospitals to back down.

Past issues of this newsletter:

Here is a quick index of past issues of our newsletter, most recent first.

Here's to a healthy rest of 2014!

Sincerely,

Patrick Malone

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